ASSISTIVE

Community

CARE

Services

Spend-down Training

2014

Presented by:

Department for Children and Families-Economic Services Division (DCF-ESD)

Department of Disabilities, Aging & Independent Living Adult Services Division (DAIL-ASD)

TRAINING OBJECTIVES:

- Learn about Medicaid for Level III RCH/ALR's
- Learn how residents become ACCS eligible with a Spend-down
- Learn ACCS provider responsibilities and procedures
- Learn admission agreement requirements for residents with a spend-down
- Learn how to verify residents' Medicaid <u>and</u>
 ACCS eligibility status

ACRONYMS

- **ACCS** Assistive Community Care Services
- **ALR** Assisted Living Residence
- **DAIL** Department of Disabilities, Aging & Independent Living
- **DHRS** Day Health Rehabilitative Services
- **DCF** Department of Children and Families
- **HP** Hewlett Packard Enterprises
- **PIL** Protected Income Level/Limit
- **RCH** Residential Care Home
- **SSI** Supplemental Security Income
- **VOE** Verification of Eligibility for Medicaid Payment of ACCS form

WHICH CAME FIRST? COMMUNITY MEDICAID

- Medicaid is a program that helps people who are lowincome pay for health care.
- Eligibility is based on financial and non-financial criteria.
- •People whose income is so low that they already have qualified for other cash assistance programs, like Supplemental Security Income or Reach Up, automatically qualify for Medicaid and are eligible immediately.
- For the purpose of this training we will focus on individuals who do not automatically qualify for Medicaid.

WHY ACCS?

- During the 1990s, AHS recognized that many residential care homes were closing.
- Residential care opportunity was diminishing for low-income people across the state.
- Medicaid coverage recognized the community health benefits of residential care homes and their services.
- ACCS was the method created to increase availability of level III residential care to lowincome Vermonters and preserve a valued private-public partnership.

WHAT IS ACCS?

- Assistive Community Care Services (ACCS) is a Community Medicaid State Plan Option for SSI and Medicaid eligible Vermonters who reside in participating residential care homes and assisted living residences.
- ACCS includes personal care and nursing oversight & assessment.
- ACCS reimburses a daily rate to enrolled providers for the cost of ACCS services.
- ACCS services are paid for by Medicaid. In some cases the cost of ACCS services may be used to spend-down to become eligible for Medicaid.
- Services are provided by level III residential care homes and assisted living residences that are enrolled as Medicaid ACCS providers.
- ACCS services are targeted to residents who need level III services who are below nursing home level of care.

ACCS RESIDENT ELIGIBILITY

To be eligible an individual must:

- Be a Vermont resident age 65 or older, or be age 18 and older with a disability.
- Meet ACCS medical and financial eligibility requirements.
 - Medical Eligibility

 need for ACCS services (personal care and nursing overview & assessment).
 - Financial Eligibility Community Medicaid.
- Live in a participating residential care home or assisted living residence that has agree to serve them through ACCS.
- Note: If a resident is approved for Choices for Care Enhanced Residential Care they are automatically eligible for ACCS.

ACCS SERVICE DEFINITIONS

ACCS Services Covered by the ACCS Payment:

- <u>Case Management</u>: to assist beneficiaries in gaining access to needed medical, social and other services. In addition to the coordination of activities required to link client/family to services specified in the beneficiary's plan of care, consultation to providers and support person(s).
- <u>Assistance with the performance of Activities of Daily Living</u>: Assistance with meals, dressing, movement, bathing, grooming, or other personal needs. The term activities of daily living is equivalent to the term personal care in the Residential Care Home Licensing Regulations.
- Medication Assistance Monitoring and Administration: Those activities defined and described in the Vermont Residential are Home Licensing Regulations.
- 24-hour On-site Assistive Therapy: Activities, techniques or methods designed to improve cognitive skills or modify behavior. Assistive therapy is furnished in consultation with a licensed professional, such as a registered or practical nurse, physician, psychologist, mental health counselor, clinical social worker, qualified mental retardation professional (QMRP), or special educator.

SERVICE DEFINITIONS CONTINUED...

- <u>Restorative Nursing</u>: Services which promote and maintain function, that are defined in the resident's service plan and may be provided in a group setting.
- Nursing Assessment: Completion of initial and periodic re-assessment of the resident and other skilled professional nursing activities which include evaluation and monitoring of resident health conditions and care planning interventions. Nursing oversight, to meet a resident's needs at the times specified by the Vermont Residential Care Home Licensing Regulations for Level III residential care homes.
- Health Monitoring: Resident observation and appropriate reporting or follow-up action by residential care home staff, in accordance with the Residential Care Home Licensing Regulations.
- Routine Nursing Tasks: Tasks performed by trained personal care or nursing staff with overview from a licensed registered nurse in accordance with the Vermont Residential Care Home Licensing Regulations and the Vermont Nurse Practice Act.

HOW DOES A RESIDENT APPLY FOR ACCS?

 If the individual <u>is not</u> already enrolled in Medicaid: Complete a 202 MED <u>Application For Health Care</u> <u>Programs</u> and submit it to DCF-

Mail to: ADPC-Application and Document Processing Center, 103 South Main St., Waterbury, VT 05676-9990.

 Individual completes section A and Provider completes section B of the VOE form and sends it in <u>with</u> the application 202 MED- Application for Health Care Programs.

202 MED APPLICATION FOR HEALTH CARE



DETERMINING COST OF CARE SERVICES

- The provider must determine the private pay rate of health related care services for ACCS form and send to DCF on the Verification of Eligibility for Medicaid Payment of Assistive Community Care Services (VOE)225A form.
- The VOE should be completed annually to reflect changes in costs.
- The VOE must ensure that you separate the private rate for room and board from the ACCS covered services.

DETERMINING COST OF CARE SERVICES

- Private Daily Rate for Room and Board includes the home's cost for:
 - Housing (mortgage, utilities, maintenance)
 - Food, meal prep
 - Transportation
 - Custodial Supervision
- Private Daily Rate for ACCS (care services only) include the home's cost for:
 - Case Management
 - Assistance with the performance of Activities of Daily Living:
 - Medication Assistance Monitoring and Administration
 - 24-hour On-site Assistive Therapy
 - Restorative Nursing
 - Nursing Assessment
 - Health Monitoring
 - Routine Nursing Tasks

225 A FORM- (VOE) VERIFICATION OF ELIGIBILITY



TIPS FOR DETERMINING COST OF CARE SERVICES

- You may include staff & other expenses required to deliver all ACCS covered services.
- You may include the cost of professional liability insurance.
- You may include the cost of 24 hour staff trained to observe and respond to personal care needs or other health needs.
- Defining the cost of care services may be useful in certain tax preparations and for business planning.

Why determine the Cost of Services?

- A resident must spend down their excess income to be eligible for Medicaid. If the deductions for medical expenses are not enough to reduce to the PIL, the cost of ACCS may be used. DCF will use the standard deduction for ACCS (as of 2014 \$42/day) or the actual cost of services if the provider has indicated the cost and it is greater than the standard deduction.
- Using the greater amount will shorten the number of days that the resident is in the private pay arrangement with the ACCS provider.

MEDICAID SPEND-DOWN

- People who appear to have too much income may become eligible for Medicaid if they incur enough medical expenses to reduce their income to the "protected income level" (PIL).
- "Spend-down" describes how medically needy individuals can reduce their income with health care expenses, until it reaches the PIL.
- A Spend-down occurs only when a resident's income is greater than the PIL and their allowable medical expenses, when paid or incurred, bring their income to the PIL.
- If income through a spend-down is reduced to the PIL the resident will be determined eligible for Medicaid.

PROTECTED INCOME LEVEL (PIL)

2014 PIL

Inside Chittenden County = **\$1066**Outside Chittenden County = **\$991**

 Theoretically the protected income level is the amount needed to meet the "medically needy" group's nonmedical needs (food, shelter, clothing, transportation etc.). Any income in excess of the PIL is then considered to be available for the group to meet its own medical expenses.

WHAT ARE THE ACCS PROVIDER REQUIREMENTS WHEN A RESIDENT IS IN AN ACCS SPEND-DOWN?

- of Need for Personal Care Services form that the individuals Medical Provider completes. DCF-ESD then requires the <u>288C Statement of Cost form</u> and may need it as often as every 6 months if the doctor checks off the individual will need this service indefinitely.
- Determine private pay rate for ACCS covered services.
- Complete the provider section of the <u>Verification of</u> <u>Eligibility</u> form with the resident and send to DCF office.
- Assist resident with forms as needed.

288 B FORM -STATEMENT OF NEED FOR PERSONAL CARE SERVICES



288 C FORM- STATEMENT OF COST



How a Spenddown is determined

- Figured on a six month basis.
- Eligible medical expenses are deducted from the individual's countable income in specific order:
 - Health Insurance.
 - Non-covered medical expenses (over the counter medications).
 - Covered medical expenses that exceed limitations (such as number of physical therapy visits).
 - Covered medical expenses that do not exceed limitations but were incurred before Medicaid eligibility was granted.
 - Cost of Assistive Community Care Services.

SPENDDOWN DETERMINATION CONTINUED...

- If net income is less than the PIL there is no spend-down. Medicaid eligibility and ACCS eligibility are the <u>same date</u>.
- If the cost of ACCC is used to meet the spenddown there will be two eligibility dates:
 - One date for Medicaid eligibility
 - A second date for ACCS eligibility.

WHAT DOES AN ACCS SPENDDOWN MEAN FOR THE PROVIDER?

- ACCS spend-down allows the resident to become eligible for Medicaid the first of the month of application. ACCS begins when all excess income has been used on allowable Spend-down expenses.
- If it has been determined that a resident will use the cost of ACCS to spend-down:
 - The resident <u>pays privately</u> for the cost of ACCS (care)
 for the number of days as indicated on the VOE. ACCS
 begins the day after the spend-down is met as indicated on
 the VOE.
 - The Provider may begin billing Medicaid for ACCS on the first day of ACCS eligibility.
 - The admission agreement must include the ACCS spend-down language so the provider may bill at a specified rate during the private pay days.

HOW TO VERIFY ACCS ELIGIBILITY?

- Malcom is only used to verify Medicaid coverage.
 It cannot be used to verify ACCS.
- Purpose of <u>Verification of Eligibility (VOE 225A)</u> is to verify the resident's ACCS eligibility status.
- O A <u>Verification of Eligibility</u> form is required for each ACCS participant!
- Verification of Eligibility form requires Resident, Provider and Eligibility Worker to sign off before it is considered complete.
- Completed copy of the <u>VOE</u> must remain in resident file.

WHAT IS THE RESIDENT RESPONSIBLE FOR?

- Applying for Medicaid using the 202 MED application
- Completing section A of the <u>Verification of Eligibility</u> (VOE 225A) form
- Paying the provider for all RCH charges until the spend-down is met
- Keeping the provider informed of any changes that may effect Medicaid and/or ACCS eligibility
- Paying the provider for room & board when they are ACCS eligible

ADMISSION AGREEMENT LANGUAGE

- Must reflect homes policy to accept Medicaid reimbursement for ACCS.
- Must reflect the services included in the ACCS bundle.
- Must reflect private pay rate for ACCS that will be in effect during ACCS Spend-down period.
- Must reflect rate for room & board during ACCS Spend-down (allowing for personal spending amount of \$65.00).

MORE ADMISSION AGREEMENT LANGUAGE

- The room and board rate will not exceed the federal portion of SSI Living Arrangement C when ACCS is paid by Medicaid
- The federal portion of SSI for room and board and the Medicaid reimbursement for ACCS are the sole reimbursement

WHO CAN ANSWER MY QUESTIONS?

• For general eligibility questions and/or case specific questions email:

AHS-HAEU-Management@state.vt.us OR AHS.ESDHCAOPS@state.vt.us

- For ACCS billing questions call **HP** Hewlet Packard Enterprises: 1-800-925-1706
- For ACCS program questions email: <u>AHS.ESDHCAOPS@state.vt.us</u>
- To enroll as an ACCS provider call **DLP**-Division of Licensing and Protection: 871-3317

ROOM AND BOARD

What a Provider must do before changing a Room & Board rate

- Before changing the room & board rate, the provider must give the resident a written notice of rate change.
 - Residential Care Homes 30 days
 - Assisted Living Residences 90 days
- Keep a copy of the rate change notice in the resident's file.

ROOM & BOARD POLICY

- DAIL has a room & board policy that Medicaid providers of ACCS and Choices for Care ERC must adhere to.
- You must include the room & board cost in your resident admission agreement.
- All resident's whose care is paid for by Medicaid must retain at least \$65 monthly for personal spending.

ROOM & BOARD -SSI INCOME

 Residents with ACCS and/or CFC ERC that have SSI for an income may be charged \$704.38/month for room and board as long as they are left with \$65 per month for personal spending.

ROOM & BOARD INCOME ABOVE SSI

- Residents that have an income greater than SSI that reside in a shared room may only be charged \$704.38/month.
- A resident in a private room that has an income greater than SSI may be charged 85% of their income after Medicaid eligibility, but the amount cannot exceed the PIL.

INCOME GREATER THAN SSI IN PRIVATE ROOM

- For the home to net an increase in the room & board charge the resident must have an income of at least \$828.68/month. (828.68 x .85 = \$704.38).
- If a resident has to spend down to be eligible for Community Medicaid and ACCS their income is the Protected Income Level (PIL). The resident has to spend down their income to the PIL to be eligible for Medicaid. Therefore for the purpose of room & board calculation, the resident's income can never exceed the current PIL.

EXAMPLES:

- Betty has SSI for an income. Her SSI is \$769.38/month. She may be charged \$704.38/month for room & board. 769.38-704.38 = \$65
- O John has social security and a railroad pension. His total monthly income is \$900.00. John lives in a private room. John's income is not over the PIL outside Chittenden County (\$991). John may be charged \$765.00/month. He will retain \$135.00 per month spending money.

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ROOM AND BOARD QUESTIONS

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